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Being a general practitioner: what it means[1]

Ian R. McWhinney

Was bedeutet es, ein Hausarzt zu sein? Die Frage nach unserem spezifischen Berufsbild sollte jede und jeder von uns möglichst klar und plastisch beantworten können. Wir sollten begründen können, warum die noch immer weit verbreitete Ansicht, die Hausarztmedizin sei nichts mehr als die Summe von (einfacher) Innerer Medizin, etwas Chirurgie, Gynäkologie, Pädiatrie usw., der Realität in keiner Weise gerecht wird. Wir tun uns aber schwer damit und haben entsprechend Mühe, die spezifische Qualität unserer Arbeit unseren Spezialisten-Kollegen und den Politikern zu vermitteln. Dabei ist das Bewusstsein für die spezifische Qualität und das Besondere der Hausarztmedizin von zentraler Bedeutung für unser Selbstbewusstsein, für die adäquate Beurteilung unserer Tätigkeit und unserer Entscheide durch Spezialisten und Spitalärzte, für die Aus- und Weiterbildung der jungen Fachkollegen und nicht zuletzt für die Einstufung unserer «Dignität» in Tariffragen.

Der Artikel von Ian McWhinney, welcher auf einem ausgezeichneten Referat am WONCA-Kongress in Wien vom Sommer 2000 basiert und den wir freundlicherweise nachdrucken dürfen, bietet hier eine wesentliche Hilfe und gibt verständliche Antworten auf die Titelfrage. Ich rufe deshalb alle Kolleginnen und Kollegen, insbesondere die standespolitisch tätigen, und natürlich auch die Politiker und Krankenkassen-Mitarbeiter unter unseren Lesern auf, diesen Artikel aufmerksam zu studieren.

Interessiert warten wir auf Ihre Meinungsäusserung dazu. Diejenigen, welche ungenügend Englisch verstehen, finden eine deutsche Zusammenfassung auf unserer Homepage www.sgam.ch.

Bernhard Rindlisbacher

Que signifie aujourd'hui être un médecin général? Chacun de nous devrait pouvoir répondre clairement et de façon plastique à cette question sur notre image professionnelle spécifique. Nous devrions pouvoir expliquer pourquoi l'idée encore si répandue que la médecine générale est tout simplement la somme d'un peu de médecine interne, de chirurgie, de gynécologie, de pédiatrie, etc., est loin d'exprimer la réalité. Mais nous n'en avons ni l'envie ni le temps, et c'est bien pour cela que nous avons peine à faire passer les spécificités de notre travail auprès de nos collègues spécialistes et auprès des politiciens. Et pourtant la conscience de la qualité et de la particularité de la médecine générale est d'une importance centrale pour notre propre estime, pour une appréciation adéquate de notre activité et de nos décisions par les spécialistes et les médecins hospitaliers, pour la formation continue de nos jeunes collègues et enfin pour l'évaluation tarifaire de notre «dignité». L'article de Ian McWhinney, qui repose sur un remarquable exposé au Congrès WONCA à Vienne au cours de l'été 2000, et que nous sommes amicalement autorisés à reproduire, fournit ici une aide essentielle et des réponses compréhensibles à cette question. J'invite donc toutes et tous les collègues – en particulier ceux qui s'engagent pour la corporation – à lire attentivement cet article, j'y invite aussi bien sûr les politiciens et les employés des caisses maladie qui se trouvent parmi nos lecteurs.

Nous attendons avec intérêt vos opinions sur ce sujet. Ceux qui craignent de comprendre insuffisamment l'anglais trouveront un résumé de l'article en français sur notre homepage sous www.ssmg.ch.

Bernhard Rindlisbacher
(Traduction: Christiane Hoffmann)

I will base my remarks mainly on my own experience and my own observations. I entered general practice in 1954 after a conventional training in internal medicine. I was well trained in some ways, but in other ways I was totally unprepared for the world that I encountered – so different from the medical world I had known. My whole career has been devoted to trying to make sense of this different world. Over the years I have found myself changing. The things I valued most then are not the same as the things I value most now. I have learned some painful lessons from my mistakes. My attitudes to illness and suffering changed, as also did my relationships with patients. I think it was a

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Prof Dr med Ian R. McWhinney
Centre for Studies in Family Medicine
Suite 245, 100 Collip Circle
CND-N6G 4X8 London, Ontario

process of becoming a general practitioner. My work in academic medicine has put me in touch with general practitioners from many different parts of the world and I have often been moved by discovering how many of them have shared this experience. It gives me some confidence in talking about the meaning of being a general practitioner. The traits I will describe are mainly positive, but also have a negative side. We need to be aware of these.

When I started in practice, the thing that gave me joy was the solving of clinical puzzles, the making of good diagnoses, thus impressing my colleagues. As time went on I found myself preoccupied more and more with the patients I had come to know. It was their joys and sorrows, their suffering and healing, that moved me. Of course, clinical diagnosis and management did not cease to be crucial: simply that a patient's illness or disability became interwoven with a life story. I came to see medicine as more complex, more context-dependent, more poignant, more a reflection of the human condition.

What is it about this relationship? To me the essential thing is that it is unconditional. All clinicians have relationships with patients. With most fields of medicine, the relationship is with a patient who has a certain disease: diabetes for the diabetologist, heart disease for the cardiologist, and so on. Other disciplines define themselves in terms of clinical content, not in terms of relationships. The relationship is conditional on the patient having a disease covered by the clinician's specialty.

In general practice, we form relationships with patients often before we know what illnesses the patient will have. The commitment, therefore, is to a person whatever may befall them. Our discipline depends on this unconditional commitment. If we allow it to break down, general practice could break into a hundred fragments. We must not say: I will care for you as long as you don't get too complicated, or as long as you don't get Aids, or become an alcoholic, or become housebound, or as long as you are not dying. Nor should we say I will care for you, but I only do psychotherapy, or palliative care, or addiction medicine. These are all splendid vocations, but they are not general practice. A patient we make a commitment to should feel assured that they will not be abandoned whatever may befall them. This commitment means that the relationship is open-ended: it is ended only by death, by geographical separation, or by mutual consent.

But suppose that we make conditions that are in the interests of health. Suppose we say: I will care for you only if you are a non-smoker, or if you give up smoking. What could be wrong with that? Is this not justifiable? I suggest not. For patients with schizophrenia, smoking is often one of their few comforts. To reject smokers would be to reject many sufferers from mental illness. In our crusade for better health would we not be failing to show compassion for the weak and the vulnerable? If we are to help sufferers from addiction, we have to be prepared to stay with them through relapses and recoveries. This is not the same as feeding in to and supporting a self-destructive life.

A number of things flow from this relationship. If successful, it allows intimacy and friendship to grow – not a social friendship, but a friendship based on a mutual interest in the patient's health and wellbeing. It will tend to be a long term relationship, since many of the ordeals our patients have to endure last for many years. At its best, the relationship will be one of trust; though trust has to be earned and it is fragile as well as precious. The relationship deepens our knowledge of our patients lives, though we must always be prepared for surprises. We may not know our patients as well as we think we do. Cumulative knowledge in a long term relationship gives us great advantages. It means that every new event can be understood in the context of a life story.

Of course, real life is not so neat as I have suggested. There never was a golden age when everything was perfect. In a mobile society, relationships end for geographic reasons. Relationships do not always work out. The rapport may not be there and it is then better for the relationship to end. Trust may fail – we all fail patients in this way at times. Sometimes we are forgiven, sometimes not. Some patients do not want a relationship let alone an intimate one. Others come to value the relationship only when they feel the need of one. Some relationships become distant when patients gravitate to secondary care with cancer or Aids or mental illness, and so become strangers to us. Because of our own

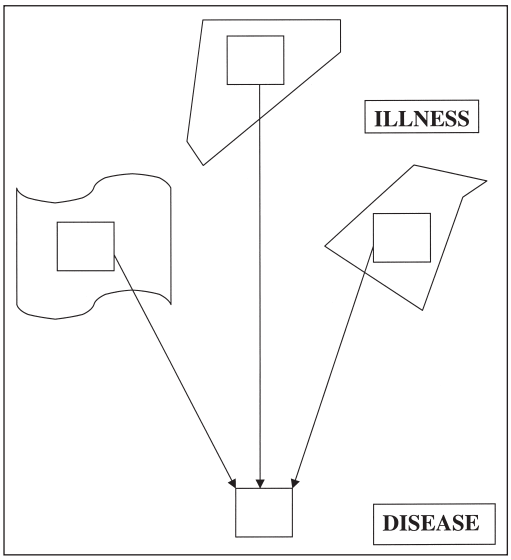
limitations, there are times when we have to transfer care to a specialist colleague, sometimes for a long period, but we never know when they may need us again.

The relationship with patients based on an unconditional commitment distinguishes us from physicians in other types of primary care, such as emergency medicine, and walk in clinics where episodic medicine followed by discharge is built into the role and where there are boundaries that cannot be crossed. The relationship deepens our knowledge, enhances our potential as healers, and opens us to a rich experience of life and medicine. But it means that we have to be very good at relationships and that requires emotional intelligence [1]. More about this later.

I believe the intimacy of our relationships is responsible for a trait I have noted in myself and my colleagues: a tendency to concrete rather than abstract thinking. In her interviews with Scottish G.P.'s, Reid [2] observed that some of them "could not talk about general practice except in terms of their specific patients". When the conversation is about a disease, we are likely to say: "that reminds me of Mrs. X". This trait is at variance with the abstractive thought which dominates most fields of medicine, especially in the medical school.

Figure 1 illustrates the process of abstraction. The three irregular shapes represent patients with similar illnesses. They are all different because no two illnesses are exactly the same. The three squares represent what the patients have in common. In the process of abstraction we take the common factors and form a disease category: multiple sclerosis, carcinoma of the lung, and so on. Abstraction gives us great predictive power and provides us with our taxonomic language. It enables us to apply our therapeutic technologies with precision. So the effectiveness of our technology depends on it. But it comes at a price. The power of generalization is gained by distancing ourselves from individual patients and all the particulars of their illness. If we look closely, as general practitioners do, every patient is different in some way. It is in the care of patients that the particulars become crucial. If we are to be healers, we need to know our patients as individuals: they may have their diseases in common, but in their responses to disease, they are unique.

Figure 1
Abstraction.



No abstraction is ever a complete picture of what it represents: it becomes less and less complete as levels of abstraction and power of generalization increase. Table 1 illustrates degrees of abstraction in a patient with multiple, fluctuating neurological symptoms. The first and lowest level is the patient's experience before it has been verbalized: his raw experience that something is not right. Level two is the patient's expressed sensations, feelings and interpretations, and their understanding by the doctor. Level three is the doctor's clinical assessment and analysis of the illness: the clinical diagnosis of multiple sclerosis. Level four is the definitive diagnosis after an MRI scan. As we increase the levels of abstraction, individual differences are ironed out in the interest of generalization. The lower levels of abstraction are closest to the patient's life world. As general practitioners we have to be prepared to work at all levels of abstraction, according to need. But the nature of the illnesses we encounter does require us often to work at the lower levels, where the power of generalization is less and closeness to the experience of the patient is maximal. As we increase the level of abstraction, the danger is that we forget that our abstraction is not the real world. The diagnosis M.S. and the MRI scan are not the patient's experience. To forget this is, in Alfred Korzybski's [3] aphorism, mistaking the map for the territory.

Our experience as general practitioners makes us somewhat skeptical of abstraction.

So many of the illnesses we encounter are such complex results of individual factors that they defy abstraction. We know that people can be seriously ill with little physical evidence of illness. Chronic pain in its many forms is typical of this type of illness. The relentless search for precision can become self-defeating. In the early stages of an illness, the evidence for a precise diagnosis may not be present. Only observation over time will reveal it. We pride ourselves on our ability to live with uncertainty. But there is a trap here. Our pride may lead us into intellectual laziness, which makes us accept levels of uncertainty which are unnecessary and harmful. A diagnosis may be missed or delayed for want of a simple, harmless, and inexpensive test, such as an E.S.R., a chest X-ray, or a blood or urine culture. Concrete thinking about individuals, carried to an extreme, may also make us blind to our practice as a population at risk, and to the health hazards in the neighborhood in which our patients live.

The concrete and the abstract are not separate dualities. They are complementary polarities. So are the polarities between uncertainty and precision. Although we can think of them independently, they are different aspects of the same reality. Each is incomplete without the other. We need to be aware of the tension between these polarities, of the need to find a balance between them, and of the pitfalls of failing to do so. What I will call organismic thinking at its best is the observation of particulars, combined with the power to see their significance as an organized whole.

I now want to turn to another complementary polarity: that between organismic and mechanistic world views. In my Pickles lecture of 1996 [4] I proposed that G.P.'s are distinguished by their organismic view of nature as contrasted with the mechanistic view which dominates modern biology and medicine. Some of those who commented maintained that this was too complicated a notion for the average physician to understand. But they misunderstood my meaning. It is not that G.P.'s *should* be organismic in their thinking: it is that we become organismic thinkers even if we do not know it We can be organismic thinkers without knowing it, just as the man in Molières' play Le Bourgeouis Gentilhomme discovered that he had been speaking prose all his life, without being aware of the fact.

What does it mean to have an organismic view of the world? Living organisms have properties possessed by no machine: growth, regeneration, healing, learning, self-organization, self-transcendence. At its most successful, medicine works by supporting these natural processes. Our therapy often consists of removing the obstacles to healing whether they are psychological or physical. The traditional regimens of balanced nutrition, rest, sound sleep, exercise, relief of pain, personal support, and peace of mind are all measures which support the organism's natural healing powers. Immunization, the most effective of all scientific advances, strengthens the body's own powers of resistance. There is now convincing evidence that personal support works in the same way, justifying our belief in the power of the doctor-patient relationship.

An organism reacts to the traumas of life as a whole. All significant illness affects the organism at every level, from the molecular

Table 1
Levels of abstraction in a patient with multiple, fluctuating, neurological symptoms and signs.

Level 1	Level 2	Level 3	Level 4
Patient's sensations and emotions	patient's expressed complaints, feelings, interpretations	doctor's analysis of illness: clinical assessment	MRI scan
Preverbal	second-order abstraction	third-order abstraction	fourth-order abstraction
Illness	"illness" (doctor's understanding)	"disease" (clinical diagnosis: multiple sclerosis)	"disease" (definitive diagnosis: MS)

Source: McWhinney IR. Textbook of Family Medicine. Oxford University Press 1997. Reproduced with permission.

to the cognitive and affective. One cannot receive a diagnosis of cancer without a profound affective response, and the type of response affects the progress of the disease. Grief can have profound effects on the body. It is possible to die from a broken heart. The holistic nature of the organism's response has been ignored by modern medicine as it has divided itself between internal medicine and psychiatry, between body and mind. The clinical method of internal medicine does not include the examination of the emotions, the clinical method of psychiatry does not include the examination of the body. The essence of our clinical method in general practice is that the body, the emotions, and the patient's experience of illness are attended to in every case, the degree of attention obviously depending on the individual circumstances. General practice is at the same time a clinical and an existential medicine. The patient-centred clinical method requires us to make a clinical diagnosis and to attend to the patient's experience. Take the apparently simple case of a patient who feels he has a "lump in the throat". I examine the throat and find it to be normal. I ask myself why he has come. I sense some anxiety, and find that he is afraid it is cancer. I assess our relationship: does he trust me enough to accept my reassurance? Is this the time to explore other sources of anxiety in his life? And so, even in a relatively minor condition, the illness is assessed as a whole, including an assessment of the doctor-patient relationship. This is organismic thinking.

The transition from mechanistic to organismic thinking requires a radical change in our notion of disease causation. Medicine has been dominated by a doctrine of specific aetiology: a cause for each disease. We have learned to think of a causal agent as a force acting in linear fashion on a passive object, as when a moving billiard ball hits a stationary one. In self-organizing systems such as organisms, causation is non-linear. The multiple feedback loops between patient and environment, and between all levels of the patient organism, require us to think in causal networks, not straight lines. Moreover, the patient as organism is not a passive object. The "specific cause" of an illness may only be the trigger which releases a process that is already a potential of the organism. The causes which maintain an illness and inhibit healing may be different from the causes which initiated it, and these may include the patient's own maladaptive behaviour, as may be the case in disability following industrial injury. Therapeutic measures may act not on a causal agent, but on strengthening the body's defences, as appears to be the case with the therapeutic benefits of human relationships.

It is true that an organism has some machine like features. That is why the organismic/mechanistic relationship is complementary. We can replace worn out joints, remove obstructions, and so on. We can reduce a patient's problem to a simple linear causal chain, as when we prescribe an antibiotic. But always, in the background is our knowledge that our intervention depends on the organism's own healing powers. One aspect of the mechanistic view is reductionism: the reduction of all etiology and therapeutics to the molecular level, regarded by many as the ultimate aim of medical science. This is the polar opposite of holism. Here again we have a complementarity between reduction and holism: two different perspectives on the same reality, each with its value, but not complete without the other.

Organismic thinking is thinking in terms of complementarity rather than duality. It is not either/or thinking, but both/and thinking. As organismic thinkers, either/or questions become meaningless to us. A leading authority on migraine wrote in the New England Journal of Medicine: [5]: "It is now time for physicians to acknowledge that migraine is a neurobiologic, not a psychogenic disorder." Our response – as organismic thinkers – should be: this statement is meaningless: diseases are not psychogenic or neurobiologic: they are both.

There is nothing new about organismic thinking. It has a pedigree in Western philosophy from Liebnitz to Alfred North Whitehead, and also in Western science: in Gestalt psychology, neurology, neuroscience, and in ethology and ecology. One of the classics of the organismicview of the body is a book called "*The Organism*" by the German neurologist Kurt Goldstein [6], published in the 1930's. The English version has just been reissued with an introduction by another organismic thinker: the neurologist Oliver Sacks. In his masterpiece "*Science and Civilization in China*", Joseph Needham [7] described the traditional Chinese world view as

organismic. He also described traditional Chinese thought as a major influence on Liebnitz. Long regarded by Western scientists as mere superstition, organismic thinking is now entering more and more into the new sciences of complexity.

I now want to turn to two other organistic/holistic concepts: Health and Healing.

Health is an organismic concept. The English words health, heal, and whole have the same linguistic roots, and I believe the same is true in other languages. We think of health as an attribute of a whole person in relation to his or her environment. When we try to promote a person's health, we look at their constitution and its strengths, their life story, their outlook on life, the factors in their daily life and work that are favourable to health. We look at how they function in their environment. Function is a wholistic concept. We also look at factors that pose threats to their health: messages from their body that things are not in balance, dietary deficiencies or excesses, addictions, mood disorders, environmental hazards, and so on. On the other hand, we think of disease prevention as targeted on specific diseases: immunizing, case finding, early diagnosis, and rehabilitation. At one end of the continuum, health promotion at the individual level borders on public and population health: at the other end it merges with clinical diagnosis and management.

That brings me to the question of healing. An organism is an individual and will have an individual response to an illness. No two people will respond in exactly the same way to a stroke, myocardial infarct or an injury. This is why prognosis is a much less precise science than diagnosis. In order to be healers for our patients, we have to know them. Organisms have astonishing powers to readjust, even to devastating losses. Healing is the restoration of wholeness, but it is often a different kind of wholeness. Serious illness or misfortune turns your life upside down: relationships, work, sense of self. A serious illness brings the sick person face to face with brute facts of existences. If we are to be healed a sense of wholeness must be restored, but this means becoming whole again as a different person: life can never be quite the same again, especially when there is chronic illness or disability. However much medicine changes, there will always be people who are yearning for healing and for a healer who can walk with them through their ordeal.

Let me tell you one story of healing. It is about a man, John Hull, a professor at Birmingham University, who gradually became blind in his forties. As a sighted person and as an Australian immigrant, he had a passionate interest in the great medieval cathedrals of Britain. When he lost his sight he despaired of ever being able to find joy in their beauty again. Then he learned to experience them in a new way, through his senses of touch and hearing. This was his path to healing, and having attained healing himself, he gave it to others. Now a blind person visiting these cathedrals will find a "Cathedral Guide for the Blind" prepared by John Hull and his friends: a scale model to be explored with the hand and an audio tape inviting him to feel the shape and texture of stone and wood, and listen to the different qualities of sound. Of course, only one in a million will find healing in this way. The path is different for each person. And healing has to come from within. It cannot be imposed, but it can be evoked: the stimulus, the spark, the catalyst can come from a healer. For Hull, it came from a friend who said "surely there are ways for you people to enjoy these places". Who better to provide that spark than a physician who has journeyed with a patient through his illness, recognized his suffering, and witnessed his struggle for wholeness. We can be healers for our patients in two ways. By practicing good clinical medicine, and by helping them to find wholeness. For this we are empowered by knowing their story, and perhaps, over the years, having been part of their story. A healer is one who walks with us, not judging us, but revealing what is most valuable in us and pointing towards the meaning of our inner pain [8].

How can we train ourselves to be healers in this sense? The essential quality is compassion, the essential skill is active, attentive listening, and the greatest danger is hardening of the heart with its companion: cynicism. The most difficult thing is to look suffering in the face without flinching. It is so easy to run away: to avoid seeing a patient, to abandon them physically, or to abandon them emotionally, busying ourselves with the chart, the tests, the computer screen, and the X-rays, hoping they won't make it too difficult for us. A colleague of mine was asked to see a young

woman with a devastating stroke: he visited her regularly, sat by her bedside and listened as she poured out her grief. She said: "You are the only one who is not afraid of me".

A great temptation is not to believe in a patient's suffering, or not believe in *them*: in the reality of their suffering or in their ability and determination to heal themselves. Why are we tempted to shy away from suffering? We are tempted because we are driven by our unexamined egocentric emotions: our fears, our helplessness, our self-interest, our likes and dislikes. And it is so easy to turn away when we are protected by those defenses by which we justify ourselves.

It is this lack of openness in the face of suffering which closes off compassion and stops us from being healers. To be healers, we have to be involved, person to person. That means setting aside our abstractions, our theories, our systems and models, and simply becoming a person responding to another person. But there are right ways and wrong ways of being involved: the wrong way is to be involved at the level of our egocentric emotions. The right way is to be both involved and detached: a seeming paradox. Our involvement must be free from self-centred attachments To achieve this detached involvement we need self-knowledge: emotional intelligence, peace of mind. This is not science as we usually understand it. We could pass examinations in psychology and sociology and be a master of interviewing techniques and still not be a healer. Yet it is trustworthy knowledge and can be validated. It can be learned and it can be taught..

This is the central message of Michael Balint's teaching, and the key skill he describes is the ability to listen. This is not listening as we usually understand it. Balint [9] called it "a new skill, necessitating a considerable, though limited, change in the doctor's personality. While discovering in himself an ability to listen to things in his patient that are barely spoken because the patient himself is only dimly aware of them, the doctor will start listening to the same kind of language in himself." The personal change Balint spoke of was the dawning of self-knowledge in the physician, and it was this self-knowledge that made the doctor's teaching – what Balint called the 'apostolic function' – a therapeutic influence tailored to the patient's needs, rather than an automatic expression of the doctor's own unexamined beliefs.

Far be it for me to claim that self-knowledge is a common or exclusive attribute of G.P.'s. In any event, it is always more of a process and aspiration than a final state of being. Yet I am impressed by the reflectiveness of many G.P.'s that I meet. Perhaps in general practice we have the beginnings of a search for self-knowledge that could transform medicine. It is self-knowledge that enables us to know where we are on the scale of these complementary polarities I have discussed, between involvement and detachment, between the organismic and mechanistic, between health promotion and disease prevention, between concrete and abstract, between the particular and the general, between uncertainty and precision. We must not underestimate the difficulty. Self-knowledge is painful. It is painful because it requires us to face the truth about ourselves. We are all very good at deceiving ourselves. It is so very difficult to see ourselves as others see us. Yet we can take active steps to attain this knowledge. We can, for example, seek out a mentor who will watch us at work and convey to us as a friend our strengths and our weaknesses. That is what a good teacher should do.

General practice is at one with the world's wisdom traditions in its emphasis on listening. Listening is at the same time a skill, a state of mind, and a way of being a physician. Attentive listening does not mean that we are unresponsive. Without the intrusion of distracting thoughts and emotions we can respond with empathy and compassion. As clinicians too, we heighten our awareness of the patient's symptoms. Learning to listen is not so much adding a skill as becoming a different kind of physician. It is a transformative rather than an additive process, a peeling away of all those resistances that make it difficult for us to be open to the life-world of others.

Of course, in the modern world there are many things that can distract our attention: time constraints, pressure of demand, pace of change. There are many things beyond our control. But our inner lives are our own responsibility. Of all that general practice can contribute to medicine, I believe self-reflectiveness is the greatest: it is the greatest because it has the power to transform every

thing we do, both as scientists and as practitioners. It can save us from those terrible things that can happen when medicine becomes captive to ideology and to its own hubris.

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